APPEAL NO. 112010
FILED MARCH 2, 2012

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on November 29, 2011, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the date of maximum medical improvement (MMI) is May 3, 2011; (2) the impairment rating (IR) is 29%; and (3) the first certification of MMI and assigned IR from [Dr. B] on May 17, 2011, did not become final under Section 408.123 and 28 TEX. ADMIN. CODE § 130.12 (Rule 130.12).

The appellant (carrier) appealed the hearing officer's MMI and IR determinations, contending that Dr. B's certification of the respondent's (claimant) MMI date and IR was not explained as required under Rule 130.1(c)(3) and Dr. B's IR evaluation did not comply with the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000 (AMA Guides). The claimant responded, urging affirmance.

The hearing officer's determination that the first certification of MMI and assigned IR from Dr. B on May 17, 2011, did not become final under Section 408.123 and Rule 130.12 was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and remanded.

The parties stipulated that the claimant sustained a compensable injury on [date of injury], and that the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed Dr. B as the designated doctor for the purpose of MMI and IR.

The claimant testified that he injured his left wrist when lifting a 50-60 pound tub of sand at work. The evidence reflects that the claimant underwent two wrist surgeries performed by [Dr. L], the claimant's current treating doctor, in 2009: (1) a left wrist arthroscopy with a triangular fibrocartilage complex (TFCC) debridement, scapholunate and lunotriquetral debridement, scapholunate and lunotriquetral pinning, capsular shrinkage on June 10, 2009; and (2) a left diagnostic wrist arthroscopy with extensive debridement and ulnar shortening osteotomy on December 9, 2009. The evidence reflects that Dr. L diagnosed the claimant with complex regional pain syndrome (CRPS).

MMI/IR

Section 401.011(30)(A) defines MMI as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated."

Section 408.0041(c) provides in pertinent part that the treating doctor and the insurance carrier are both responsible for sending to the designated doctor all of the injured employee's medical records relating to the issue to be evaluated by the designated doctor that are in their possession.

Section 408.1225(c) provides that the report of the designated doctor has presumptive weight, and the Division shall base its determination of whether the employee has reached MMI on the report of the designated doctor unless the preponderance of the other medical evidence is to the contrary.

Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Division shall base the IR on that report unless the preponderance of the other medical evidence is to the contrary, and that, if the preponderance of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Division, the Division shall adopt the IR of one of the other doctors.

Rule 130.1(c)(3) provides in pertinent part that the assignment of an IR shall be based on the injured worker's condition as of the MMI date considering the medical record and the certifying examination and the doctor assigning the IR shall:

(A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;

(B) document specific laboratory or clinical findings of an impairment;

(C) analyze specific clinical and laboratory findings of an impairment;

(D) compare the results of the analysis with the impairment criteria and provide the following:

(i) [a] description and explanation of specific clinical findings related to each impairment, including [0%] [IRs]; and

(ii) [a] description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

Dr. B examined the claimant on May 18, 2011, and in his narrative report dated August 9, 2011, certified that the claimant reached MMI statutorily on May 3, 2011, with 29% IR. We note that the parties did not stipulate as to the date of statutory MMI, although Dr. B indicated in his Report of Medical Evaluation (DWC-69) that May 3, 2011, was the date of statutory MMI. The evidence reflects that Dr. B noted in his narrative report (attached to his DWC-69) that the accepted compensable injury by the carrier is a left wrist/hand joint derangement. Dr. B also stated that he rated CRPS (sensory and motor impairments for the ulnar and median nerves) as part of the compensable injury. In Finding of Fact No. 4, the hearing officer determined that the IR evaluation of Dr. B was performed in accordance with the AMA Guides. In Finding of Fact No. 5, the hearing officer determined that the May 3, 2011, date of MMI and 29% IR certified by Dr. B is not contrary to the preponderance of the evidence. The hearing officer adopted Dr. B's certification of MMI/IR[1] and determined that the date of MMI is May 3, 2011, and the IR is 29%.

In reviewing a "great weight" challenge, we must examine the entire record to determine if: (1) there is only "slight" evidence to support the finding; (2) the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust; or (3) the great weight and preponderance of the evidence supports its nonexistence. *See* Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

Dr. B stated in his narrative report dated August 9, 2011, that he had no medical records to review for his certifying exam (with the exception of an EMG/NCV study performed on June 4, 2011). In a letter dated September 15, 2011, Dr. L, the claimant's treating doctor, stated that "[t]he fact that bothers me the most, is that neither one of them [Dr. B or [Dr. C], a post-designated doctor required medical examination (RME) doctor] have attempted to obtain all of the records regarding surgery, and the fact that [Dr. C] has not acknowledged the fact that the [claimant] had [CRPS]." We further note that Dr. B failed to comply with the requirements of Rule 130.1(c)(3) because Dr. B failed to include any information in his narrative report or in worksheets to establish how he arrived at his assessment of impairment for the claimant's peripheral nerve system or CRPS under the rating criteria of the AMA Guides, page 3/36. Furthermore, Dr. B had a mathematical error in the calculation of range of motion (ROM) deficits for the left wrist based on his measurements.

Rule 127.10(a)(1) provides in pertinent:

> The treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records

[1] We note that Dr. B provided an alternative certification of MMI/IR that included a disputed body part, the right shoulder. However, the claimant testified at the CCH that he had never claimed a right shoulder injury.

in their possession relating to the medical condition to be evaluated by the designated doctor.

In Appeals Panel Decision (APD) 062068, decided December 4, 2006, we held that the 1989 Act and the Division rules require that the designated doctor conduct an examination of the claimant and review the claimant's medical records. The Appeals Panel stated that ". . . Rule 130.1(b)(4)(A) and 130.1(c)(3) specifically require that the certifying doctor, including the designated doctor, review the medical records before certifying an MMI date and assigning an IR." Accordingly, Dr. B's certification of MMI/IR cannot be adopted. Because Dr. B did not have the claimant's medical records before certifying an MMI date and assigning an IR and because Dr. B did not perform an IR evaluation in accordance with the AMA Guides, the hearing officer's Findings of Fact Nos. 4 and 5 are so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. We reverse the hearing officer's determinations that the date of MMI is May 3, 2011, and the IR is 29% as certified by Dr. B.

There are three other certifications of MMI/IR in evidence, which constitute conflicting medical evidence.

[Dr. S] was initially appointed by the Division as the designated doctor for the issues of MMI/IR. Dr. S examined the claimant on May 27, 2010, and certified that the claimant was not at MMI but was expected to reach MMI on or about August 27, 2010. Dr. S diagnosed the claimant's injury as "[l]eft wrist strain. TFCC tear ([status/post] osteotomy)." Dr. S's explanation why the claimant was not at MMI included future scheduled treatment.

[Dr. CA], the second designated doctor appointed on the issues of MMI/IR, examined the claimant on November 30, 2010, and certified that the claimant was not at MMI but was expected to reach MMI on or about March 2, 2011. Dr. CA diagnosed the claimant's injury as "[s]tatus post left wrist, arthroscopic surgery, with debridement and capsular shrinkage procedure. Status post left ulnar osteotomy with shortening. Status post delayed nonunion, healed now. Severe limitation of [ROM] of the left wrist with a significant amount of pain and fear avoidance." Dr. CA's explanation why the claimant was not at MMI included future scheduled treatment.

Dr. C, the RME doctor, examined the claimant on August 2, 2011, and certified that the claimant reached clinical MMI on January 4, 2011, with 10% IR. The evidence reflects that Dr. C noted in his narrative report (dated August 2, 2011, and attached to his DWC-69) that he diagnosed the compensable injury as a left wrist sprain with TFCC tear status post-surgery. Dr. C explained that his certified MMI date of January 4, 2011, is supported by Dr. L's medical record dated that same date in which Dr. L noted that the claimant's symptoms had improved. Dr. C stated in his report that "[s]ince that time

no significant change has been experienced in his condition and no treatment rendered has altered his condition." Dr. C additionally stated in his narrative:

> As an aside, I would note that in Dr. [B's] report, he referenced CRPS in his terminology for rating. It should be understood that there is no specific rating listed in the AMA Guides for CRPS or [reflex sympathetic dystrophy (RSD)]. Rather, the rating is based upon the physical presentations of sensory or motor loss and/or [ROM] restriction. However, at today's examination [August 2, 2011], there were no clinical findings that would support the diagnosis of CRPS. If he had the condition in the past, then the absence of the findings would be confirmation of MMI.

Regarding Dr. C's IR evaluation, we note that after calculating the ROM deficits for the left wrist, Dr. C performed and documented sensory testing for the ulnar and median nerves. However, he only provided an explanation for assigning an impairment for the motor deficits of the ulnar nerve without going through the same analysis using Tables 12 and 15, pages 3/49 and 3/54 respectively, of the AMA Guides for the median nerve. Dr. C failed to assign any impairment, including 0% impairment, for motor deficits of the median nerve. The claimant argued at the CCH that Dr. C's IR did not rate the entire compensable injury.

Because there is conflicting medical evidence regarding MMI/IR, the Appeals Panel cannot adopt the certification of MMI and/or IR of the other certifying doctors, Dr. S, Dr. CA, and Dr. C. Accordingly, we remand the issues of MMI and IR to the hearing officer for the hearing officer to make determinations on MMI and IR consistent with this decision.

REMAND INSTRUCTIONS

On remand, the hearing officer should allow the parties an opportunity to stipulate to the date of statutory MMI. If the parties are unable to stipulate, the hearing officer should take additional evidence to determine the date of statutory MMI in order to inform the designated doctor of the date of statutory MMI. The hearing officer should ensure that the treating doctor and insurance carrier shall send to the designated doctor all of the claimant's medical records that are in their possession relating to the issue to be evaluated by the designated doctor.

We note the certifying doctors involved in this case, Dr. B, Dr. S, Dr. CA, and Dr. C, have certified MMI/IR based on differing diagnoses of the claimant's compensable left wrist injury.

Dr. B is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. B is still qualified and available to be the designated doctor. If Dr. B is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed pursuant to Rule 127.5(c) to determine MMI and IR for the compensable injury. The hearing officer is to advise the designated doctor what the date of statutory MMI is and which body parts or conditions are in dispute. The designated doctor is then to be requested to give an opinion on MMI (which cannot be after the statutory MMI date) and to provide multiple certifications of IR that take into account the various body parts and conditions that are in dispute.

The parties are to be provided with the hearing officer's letter to the designated doctor and the designated doctor's response. The parties are to be allowed an opportunity to respond.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Division, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* APD 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **AMERISURE INSURANCE COMPANY** and the name and address of its registered agent for service of process is

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Cynthia A. Brown
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Margaret L. Turner
Appeals Judge